### Policy Statement

Biofeedback in the outpatient setting is considered **investigational** as a treatment of urinary incontinence in adults.

Unsupervised home use of biofeedback for treatment of urinary incontinence is considered **investigational**.

### Policy Guidelines

#### Coding

**Effective January 1, 2020,** there are new CPT codes that may be billed for biofeedback for urinary incontinence:

- **90912:** Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient
- **90913:** Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient (List separately in addition to code for primary procedure)

Biofeedback for urinary incontinence may be billed with the following CPT and HCPCS codes:

- **90911:** Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry *(Deleted code effective 1/1/2020)*
- **E0746:** Electromyography (EMG), biofeedback device

#### Description

Biofeedback is a technique to teach patients self-regulation of physiologic processes not generally considered to be under voluntary control; a variety of approaches and devices are available. Biofeedback, in conjunction with pelvic floor muscle training (PFMT), is proposed as a treatment of urinary incontinence.

#### Related Policies

- Injectable Bulking Agents for the Treatment of Urinary and Fecal Incontinence
- Pelvic Floor Stimulation as a Treatment of Urinary and Fecal Incontinence
- Percutaneous Tibial Nerve Stimulation
- Sacral Nerve Neuromodulation/Stimulation

#### Benefit Application

Benefit determinations should be based in all cases on the applicable contract language. To the extent there are any conflicts between these guidelines and the contract language, the contract language will control. Please refer to the member's contract benefits in effect at the time of service to determine coverage or non-coverage of these services as it applies to an individual member.

Some state or federal mandates (e.g., Federal Employee Program [FEP]) prohibits plans from denying Food and Drug Administration (FDA)-approved technologies as investigational. In these
instances, plans may have to consider the coverage eligibility of FDA-approved technologies on the basis of medical necessity alone.

### Regulatory Status

A variety of biofeedback devices have been cleared for marketing by the U.S. Food and Drug Administration through the 510(k) process. The Food and Drug Administration defines a biofeedback device as “an instrument that provides a visual or auditory signal corresponding to the status of one or more of a patient's physiological parameters (e.g., brain alpha wave activity, muscle activity, skin temperature, etc.) so that the patient can control voluntarily these physiological parameters.” Food and Drug Administration product code: KPI.

### Rationale

**Background**

Biofeedback is intended to teach patients self-regulation of certain physiologic processes not normally considered to be under voluntary control. The technique involves feedback on a variety of types of information not commonly available to the patient, followed by a concerted effort on the part of the patient to use this feedback to help alter the physiologic process in some specific way. Biofeedback has been proposed as a treatment for a variety of diseases and disorders, including anxiety, headaches, hypertension, movement disorders, incontinence, pain, asthma, Raynaud disease, and insomnia. Biofeedback training is done either in individual or group sessions and as a single therapy or in combination with other therapies designed to teach relaxation. A typical program consists of 10 to 20 training sessions of 30 minutes each. Training sessions are performed in a quiet, non arousing environment. Subjects are instructed to use mental techniques to affect the physiologic variable monitored, and feedback is provided for the successful alteration of the physiologic parameter. This feedback may be in the form of signals, such as lights or tone, verbal praise, or other auditory or visual stimuli.

Biofeedback, in conjunction with pelvic floor muscle training, is a possible treatment modality for stress, urge, mixed, and overflow urinary incontinence because it may enhance awareness of body functions and the learning of exercises to train pelvic muscles. Several proposed biofeedback methods that may be employed to treat urinary incontinence, including vaginal cones or weights, perineometers, and electromyographic systems with vaginal and rectal sensors.

The various forms of biofeedback mainly differ in the nature of the disease or disorder under treatment, the biologic variable that the subject attempts to control, and the information that is fed back to the subject. Biofeedback techniques include peripheral skin temperature feedback, blood-volume-pulse feedback (vasoconstriction and dilation), vasoconstriction training (temporalis artery), and electromyographic biofeedback; they may be used alone or in conjunction with other therapies (e.g., relaxation, behavioral management, medication).

### Literature Review

Evidence reviews assess the clinical evidence to determine whether the use of technology improves the net health outcome. Broadly defined, health outcomes are the length of life, quality of life (QOL), and ability to function—including benefits and harms. Every clinical condition has specific outcomes that are important to patients and managing the course of that condition. Validated outcome measures are necessary to ascertain whether a condition improves or worsens, and whether the magnitude of that change is clinically significant. The net health outcome is a balance of benefits and harms.

To assess whether the evidence is sufficient to draw conclusions about the net health outcome of technology, two domains are examined: the relevance, and quality and credibility. To be relevant, studies must represent one or more intended clinical use of the technology in the...
intended population and compare an effective and appropriate alternative at a comparable intensity. For some conditions, the alternative will be supportive care or surveillance. The quality and credibility of the evidence depend on study design and conduct, minimizing bias and confounding that can generate incorrect findings. The randomized controlled trial (RCT) is preferred to assess efficacy; however, in some circumstances, nonrandomized studies may be adequate. RCTs are rarely large enough or long enough to capture less common adverse events and long-term effects. Other types of studies can be used for these purposes and to assess generalizability to broader clinical populations and settings of clinical practice.

Several methodologic difficulties arise in assessing biofeedback. Most interventions that include biofeedback are multimodal and include relaxation and behavioral instruction, which may have effects separate from those due to biofeedback. While studies may report a beneficial effect of multimodality treatment, without appropriate control conditions, it is impossible to isolate the specific contribution of biofeedback to the overall treatment effect. For example, relaxation, attention, or suggestion may account for successful results that have been attributed to biofeedback. These effects are nonspecific therapeutic factors, some of which can be considered placebo effects. To demonstrate the efficacy of biofeedback for treating incontinence, studies are needed to isolate the effect of biofeedback and demonstrate an improvement in health outcomes compared with other interventions (e.g., relaxation or behavioral therapy alone). In addition, although research has shown that feedback on physiologic processes has enhanced patients' ability to control these processes, the evidence is needed on the relationship between a patient's ability to exert control over the targeted physiologic process and any health benefits of the intervention. The latter finding underscores the importance of seeking controlled studies showing whether the use of biofeedback improves disease-related health outcomes, as opposed to physiologic, intermediate outcomes.

Women With Urinary Incontinence
Clinical Context and Therapy Purpose
The purpose of biofeedback with pelvic floor muscle training (PFMT) in women who have urinary incontinence is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of biofeedback with PFMT improve the net health outcome in women with urinary incontinence?

The following PICOs were used to select literature to inform this review.

Patients
The relevant population of interest are women with urinary incontinence.

Urinary incontinence is a common condition defined as involuntary leakage of urine. Women are twice as likely to be affected as men, and prevalence increases with age. The severity of incontinence affects the QOL and treatment decisions. The types of urinary incontinence women may experience include stress, urge, overflow, and functional. Nonsurgical treatment options may include pharmacologic treatment, pelvic muscle exercises, bladder training exercises, electrical stimulation, and neuromodulation.

Interventions
The therapy being considered is biofeedback with PFMT, which is provided in an outpatient setting by a skilled therapist.

Comparators
The following therapy is currently being used to make decisions about urinary incontinence: PFMT without biofeedback which is provided in an outpatient setting by a skilled therapist or personal PFMT performed at home.
Outcomes
The general outcomes of interest are symptom improvement (e.g., incontinence episodes) and functional improvement (generally 1-4 treatments per week, for 8-12 weeks).2

Table 1. Outcomes Measures for Women With Urinary Incontinence

<table>
<thead>
<tr>
<th>Measure</th>
<th>Outcome Evaluated</th>
<th>Description</th>
<th>Follow-up Timing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oxford Grading Scale</td>
<td>Functional improvement</td>
<td>Used by physiotherapists to assess muscle strength as graded 0 to 5.3</td>
<td>Baseline and at end of therapy</td>
</tr>
<tr>
<td>Pelvic Floor Muscle Function</td>
<td></td>
<td>0 = no movement</td>
<td>(8-12 weeks)</td>
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<tr>
<td></td>
<td></td>
<td>1 = flicker of movement</td>
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<td></td>
<td></td>
<td>2 = through full range actively with gravity counterbalanced</td>
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<td></td>
<td>3 = through full range actively against gravity</td>
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<td></td>
<td>4 = through full range actively against some resistance</td>
<td></td>
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<td></td>
<td></td>
<td>5 = through full range actively against strong resistance</td>
<td></td>
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<tr>
<td>PERFECT Scheme</td>
<td>Functional improvement</td>
<td>A way of measuring pelvic muscle function and strength. PERFECT stands for</td>
<td>Baseline and at end of therapy</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Power (Modified Oxford Scale)</td>
<td>(8-12 weeks)</td>
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<tr>
<td></td>
<td></td>
<td>Endurance (how long contraction is held, up to 10 s)</td>
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<td></td>
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<td>Repetitions (up to 10 repetitions of a 10-s hold)</td>
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<td>Fast (number of 1-s contractions in a row, up to 10)</td>
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<tr>
<td></td>
<td></td>
<td>Every Contraction Timed (reminder to time every contraction)</td>
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</tr>
</tbody>
</table>

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Study Selection Criteria
Methodologically credible studies were selected using the following principles:

a. To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;

b. In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;

c. To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;

d. Studies with duplicative or overlapping populations were excluded.

Systematic Reviews
In their systematic review, Mateus-Vasconcelos et al (2018) assessed various physiotherapy methods to strengthen the pelvic floor muscles for women with stress urinary incontinence.5 Their review included a mix of RCTs, quasi-experimental trials, and systematic reviews—a total of six studies. Only one study (an uncontrolled RCT) included biofeedback as a comparator. That study (Pinheiro et al[2012]) compared the effectiveness of PFMT with biofeedback (group n=6) to PFMT with palpation (group n=5). The exercises for the biofeedback group consisted of achieving the same number of rapid and slow contractions of the same duration as that achieved during the PERFECT scheme, which stands for power, endurance, repetitions, fast contractions, and every contraction timed (eight series).6 The palpation group strengthened the pelvic floor muscles while a physiotherapist performed palpations on the central perineal tendon and vagina (four sessions). At the end of treatment, there was no statistical difference in improvement between the biofeedback group and the palpation group in power, endurance, or rapidity of contractions. This RCT was limited in its small sample size and lack of control group and masking of assessors.

Moroni et al (2016) published a systematic review of 37 RCTs evaluating conservative treatment of stress urinary incontinence in women.7 Five trials (total n=250 women) were identified that compared PFMT plus biofeedback with biofeedback alone. A pooled analysis of 4 studies found
Biofeedback as a Treatment of Urinary Incontinence in Adults

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significantly more urine loss as measured by a posttreatment pad test with PFMT alone than with PFMT plus biofeedback (mean difference, 0.90; 95% confidence interval [CI], 0.71 to 1.10). Reviewers noted that the difference between groups was likely not clinically significant because there was only about a 1-gram difference. Moreover, the finding was largely due to the effect of a single study. Results on other outcomes (e.g., QOL, number of incontinence episodes) could not be pooled due to the imprecision of the estimates.

In an Agency for Healthcare Research and Quality comparative effectiveness review, Shamliyan et al (2012) identified 6 RCTs (total n=542 patients) comparing PFMT plus biofeedback with PFMT alone. A meta-analysis of these studies did not find a statistically significant difference between interventions in incontinence rates. When the findings were pooled, the relative risk was 1.27 (95% CI, 0.88 to 1.85). The absolute risk difference was 0.08 (95% CI, -0.03 to 0.19).

In a Cochrane systematic review, Herderschee et al (2011) assessed RCTs on feedback or biofeedback in conjunction with PFMT for treating urinary incontinence in women. Feedback was defined as verbal feedback by a clinician, whereas biofeedback involved use of an instrument or device. After examining 36 full-text articles, 24 trials met reviewers' eligibility criteria, and 17 contributed data to the analysis of at least 1 primary outcome measure. Sixteen of the 24 trials compared PFMT plus biofeedback with PFMT alone; 9 of them included the same PFMT programs in both groups. The primary outcomes of the review were QOL and improvement or cure. Nine trials used one of several validated QOL instruments; however, only four of them reported data in a form amenable to meta-analysis. Thus, the QOL results was not pooled. Data were pooled for the other primary outcome (improvement or cure) but there was a sufficient number of studies only for comparing PFMT with and without biofeedback. In a pooled analysis of 7 studies, there was a significant reduction in the proportion of women reporting "no improvement or cure" when biofeedback was added to muscle exercise (relative risk, 0.75; 95% CI, 0.66 to 0.86). Reviewers noted there may have been other differences between groups, such as more frequent contact with a health care professional or a greater number of treatment sessions, which might partially explain the difference between the improvement or cure rates in women who did or did not receive biofeedback. Moreover, when only the outcome "no cure" was examined, there was no significant difference between groups that did and did not receive biofeedback (5 studies; relative risk, 0.92; 95% CI, 0.81 to 1.05). Among secondary outcomes, a pooled analysis of 7 trials did not find a significant difference in leakage episodes in a 24-hour period after treatment (mean difference, -0.01; 95% CI, -0.21 to 0.01). For the outcomes frequency and nocturia, data could not be combined but reviewers reported that the pattern was one of no difference between groups.

As implied in the description of the Cochrane review, studies evaluating biofeedback for treating urinary incontinence in women have used various combinations of interventions and comparator interventions. Selected larger RCTs that compared PFMT with and without biofeedback (to isolate the effect of biofeedback and published as full articles are described next).

Randomized Controlled Trials

Burgio et al (2002) reported on the findings of an RCT with 222 women who had the urge or mixed incontinence. Interventions in this 3-armed trial were as follows: (1) 74 patients received behavioral training along with digital palpation instruction (no biofeedback) and 4 office visits in 8 weeks; (2) 73 patients received biofeedback-assisted behavioral training and 4 office visits in 8 weeks; and (3) 75 patients were given a self-help book with no office visits (control condition). Behavioral training in the two intervention groups included teaching pelvic floor exercises as well as skills and strategies for reducing incontinence. Patients in all groups kept bladder diaries through the eight-week treatment period. In an intention-to-treat analysis, the mean reduction in incontinence episodes was 69.4% in the behavioral training plus verbal feedback group, 63.1% in the behavioral training plus biofeedback group, and 58.6% in the control group. The 3 groups did not differ significantly from one another (p = 0.23). In addition, QOL outcomes was similar in the three groups.
Williams et al (2006) published a study that included 238 women who had failed a primary behavioral therapy (e.g., advice on fluid intake, bladder reeducation, weight loss) for 3 months. They were randomized to intensive PFMT (n=79), PFMT using vaginal cones (n=80), or continued behavioral therapy (n=79) for 3 months. Patients in all 3 groups were seen in the clinic every other week for 8 weeks and at 12 weeks. At 12 weeks, all 3 groups had moderate reductions in incontinence episodes and some reduction in voiding frequency; there were no statistically significant differences in outcomes among the 3 groups. For example, the mean reduction in incontinence episodes over 24 hours was -1.03 in the PFMT group, -0.28 in the vaginal cone group, and -0.59 in the control group (p=0.2).

Other RCTs comparing the efficacy of PFMT alone with PFMT with biofeedback have been published. They tended not to find statistically significant differences in outcomes between interventions; however, sample sizes were small (i.e., <25 per group) and thus the studies might have been underpowered.

**Section Summary: Women With Urinary Incontinence**

Numerous RCTs and several systematic reviews have evaluated biofeedback as a treatment for urinary incontinence in women. Trial reporting methodologies varied, and many did not isolate the potential contribution of biofeedback. A comparative effectiveness review did not find a statistically significant difference in continence rates when patients received PFMT with or without biofeedback. Other systematic reviews evaluating biofeedback and/or verbal feedback as part of treatment for urinary incontinence found improvement in some outcomes (e.g., improvement or cure, urine volume) but not others (e.g., cure, leakage episodes). There is a lack of consistent evidence from well-designed trials to suggest that biofeedback is an effective treatment for urinary incontinence.

**Men With Prostatectomy-related Urinary Incontinence**

**Clinical Context and Therapy Purpose**

The purpose of biofeedback with PFMT in men who have post-prostatectomy urinary incontinence is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of biofeedback with PFMT improve the net health outcome in men with post-prostatectomy urinary incontinence?

The following PICOs were used to select literature to inform this review.

**Patients**

The relevant populations of interest are men with post-prostatectomy urinary incontinence.

**Interventions**

The therapy being considered is biofeedback with PFMT, which is provided in an outpatient setting by a skilled therapist.

**Comparators**

The following therapy is currently being used to make decisions about urinary incontinence: PFMT without biofeedback, which is provided in an outpatient setting by a skilled therapist or personal PFMT performed at home.

**Outcomes**

The general outcomes of interest are symptom reduction and functional outcomes (approximately eight weeks).

**Study Selection Criteria**

Methodologically credible studies were selected using the following principles:
Biofeedback as a Treatment of Urinary Incontinence in Adults

To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;

In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies.

To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought.

Studies with duplicative or overlapping populations were excluded.

Systematic Reviews

A Cochrane review by Anderson et al (2015) assessed conservative treatments for post-prostatectomy urinary incontinence.14 Reviewers included a comparison of PFMT (with or without biofeedback) and sham or no treatment. They did not evaluate the potential incremental value of biofeedback (i.e., by comparing PFMT with biofeedback and PFMT without biofeedback).

Hsu et al (2016) published a systematic review of PFMT with biofeedback in men who had had a radical prostatectomy.15 Thirteen trials met reviewers' inclusion criteria. However, on inspection, not all trials included a biofeedback intervention, and other trials did not compare PFMT alone with PFMT plus biofeedback. Thus, conclusions about the added efficacy of biofeedback could not be determined from the results of this meta-analysis.

Previously, MacDonald et al (2007) conducted a systematic review of PFMT to improve urinary incontinence after radical prostatectomy.16 Reviewers identified 3 studies (281 men) that compared biofeedback and PFMT with muscle training alone (written/verbal instructions provided). Study findings were not pooled; none of the individual trials included in the review found a statistically significant difference in outcomes between groups.

Randomized Controlled Trials

Goode et al (2011) reported on an RCT evaluating biofeedback and PFMT in 208 men with urinary incontinence persisting at least 1 year after radical prostatectomy.13 Men with pre-prostatectomy incontinence were excluded. Participants were randomized to 1 of 3 groups: 8 weeks of behavioral therapy (PFMT and bladder control exercises; n=70), behavioral therapy plus biofeedback and electric stimulation (n=70), and a delayed-treatment control group (n=68). The biofeedback and electric stimulation intervention, called “behavior-plus,” consisted of in-office electric stimulation with biofeedback using an anal probe and daily home pelvic floor electrical stimulation. After 8 weeks, patients in the 2 active treatment groups were given instructions for a maintenance program of pelvic floor exercises and fluid control; they were assessed at 6 and 12 months. The primary efficacy outcome was a reduction in the number of incontinent episodes at eight weeks, as measured by a seven-day bladder diary. A total of 176 (85%) of 208 randomized men completed the 8-week treatment. In an intention-to-treat analysis of the primary outcome, the mean reduction in incontinent episodes was 55% (28-13 episodes per week) in the behavioral therapy group, 51% (26-12 episodes per week) in the behavior-plus group, and 24% (25-20 episodes per week) in the control group. The overall difference between groups was statistically significant (p=0.001), but the behavior plus intervention did not result in a significantly better outcome than behavioral therapy alone. Findings were similar to other outcomes. For example, at the end of 8 weeks, there was a significantly higher rate of complete continence in the active treatment groups (11/70 [16%] in the behavior group vs 12/70 [17%] in the behavior-plus group) than the control group (4/68 [6%]), but the group receiving biofeedback and electrical stimulation did not have a significantly higher continence rate than the group receiving behavioral therapy alone.

Section Summary: Post-Prostatectomy Urinary Incontinence

RCTs have evaluated the efficacy of biofeedback with PFMT for treatment of prostatectomy-related urinary incontinence compared with PFMT without biofeedback. These trials had mixed findings, and have not consistently reported significantly improved outcomes with biofeedback.
added to the intervention. The timing and delivery of the intervention were not well-defined. Systematic reviews have not pooled study findings.

**Planned Radical Prostatectomy**

**Clinical Context and Therapy Purpose**

The purpose of biofeedback with PFMT in men who are scheduled for radical prostatectomy is to provide a treatment option that is an alternative to or an improvement on existing therapies.

The question addressed in this evidence review is: Does the use of biofeedback with PFMT improve the net health outcome in men scheduled for radical prostatectomy?

The following PICOs were used to select literature to inform this review.

**Patients**

The relevant populations of interest are men scheduled for radical prostatectomy.

**Interventions**

The therapy being considered is biofeedback with PFMT, which is provided in an outpatient setting by a therapist.

**Comparators**

The following therapy is currently being used to make decisions about urinary incontinence: PFMT without biofeedback, which is provided in an outpatient setting by a skilled therapist or personal PFMT performed at home.

**Outcomes**

The general outcomes of interest are symptom prevention and functional outcomes (starting two-four weeks before the procedure and continuing after; follow-up six months). 17

**Study Selection Criteria**

Methodologically credible studies were selected using the following principles:

- To assess efficacy outcomes, comparative controlled prospective trials were sought, with a preference for RCTs;
- In the absence of such trials, comparative observational studies were sought, with a preference for prospective studies;
- To assess long-term outcomes and adverse events, single-arm studies that capture longer periods of follow-up and/or larger populations were sought;
- Studies with duplicative or overlapping populations were excluded.

**Randomized Controlled Trials**

A few trials have evaluated the use of pre- or perioperative biofeedback for patients undergoing radical prostatectomy for prevention of postoperative urinary incontinence.

Tienforti et al (2012) reported on an RCT comparing biofeedback (sessions before and after surgery) plus pelvic floor muscle exercises with a control intervention PFMT alone in patients undergoing radical prostatectomy. 18 The trial enrolled 34 patients, 32 of whom (16 in each group) were available for the final 6-month analysis. By 6 months, 10 (62.5%) of 16 patients in the treatment group and 1 (6.3%) of 16 patients in the control group were continent (p=0.002). The mean number of incontinence episodes per week was also significantly lower in the intervention group (2.7) than in the control group (13.1) at 6 months (p=0.005).

A trial by Wille et al (2003) randomized 139 men prior to radical prostatectomy to 1 of 3 groups. 19 Group 1 received verbal and written instructions about PFMT from a physical therapist. Group 2 received PFMT instruction and instruction on using an electrical stimulation device. Group 3 received the previous two intervention components and training on using biofeedback with the electrical stimulation device. Patients had regular contact with a health care provider.
for the first five weeks after surgery. In the immediate postsurgical period, 20.5% in group 1, 22.9%
in group 2, and 20.7% in group 3 were continent (p=0.815). After 6 and 12 months, continence
rates remained similar among the groups. Twelve-month continence rates were 88% in group 1,
81% in group 2, and 88.6% in group 3 (p=0.524).

Bales et al (2000) randomized 100 men scheduled to undergo radical prostatectomy to PFMT
plus biofeedback intervention (n=50) or to a control group (n=50) that received written and brief
verbal instructions performing PFMT. The intervention consisted of a single session with a trained
nurse two to four weeks before surgery. Three men dropped out of the PFMT plus intervention
group. At 6 months after surgery, there was no difference between groups; the incidence of
urinary incontinence was 94% (44/47) in the PFMT plus biofeedback group and 96% (948/40) in
the control group.

**Section Summary: Men Scheduled for Radical Prostatectomy**

RCTs have evaluated the efficacy of biofeedback with PFMT for prevention of prostatectomy-
related urinary incontinence compared with PFMT without biofeedback. These trials generally
reported poor outcomes with biofeedback added to the intervention. The timing and delivery of
the intervention were not well-defined.

**Summary of Evidence**

For individuals who have urinary incontinence (women) who receive biofeedback with PFMT,
the evidence includes RCTs and systematic reviews. The relevant outcomes are symptoms,
functional outcomes, and QOL. A comparative effectiveness review did not find a statistically
significant difference in continence rates when patients received PFMT with or without
biofeedback. Other systematic reviews evaluating biofeedback and/or verbal feedback as part
of treatment for urinary incontinence found improvement in some outcomes but not others.
There is a lack of consistent evidence from well-designed trials that biofeedback effectively
treats urinary incontinence. The evidence is insufficient to determine the effects of the
technology on health outcomes.

For individuals who have post-prostatectomy urinary incontinence or who are scheduled for
radical prostatectomy who receive biofeedback with PFMT, the evidence includes RCTs and
systematic reviews. The relevant outcomes are symptoms, functional outcomes, and QOL.
Several RCTs have compared PFMT with or without biofeedback in men undergoing radical
prostatectomy, and in men with post-prostatectomy urinary incontinence. These trials had
mixed findings but did not consistently report significantly improved outcomes when
biofeedback was added to the intervention. The timing and delivery of the intervention were
not well-defined. Additional well-designed trials are needed that demonstrate the superiority of
biofeedback with PFMT over PFMT alone. The evidence is insufficient to determine the effects of
the technology on health outcomes.

For individuals who will undergo radical prostatectomy, RCTs have evaluated the efficacy of
biofeedback with PFMT compared with PFMT without biofeedback for prevention of
prostatectomy-related urinary incontinence. These trials generally reported poor outcomes with
biofeedback added to the intervention. The timing and delivery of the intervention were not
well-defined.

**Supplemental Information**

Clinical Input From Physician Specialty Societies and Academic Medical Centers

While the various physician specialty societies and academic medical centers may collaborate
with and make recommendations during this process, through the provision of appropriate
reviewers, input received does not represent an endorsement or position statement by the
physician specialty societies or academic medical centers, unless otherwise noted.

In response to requests from Blue Cross Blue Shield Association, input was received from 4
physician specialty societies and 2 academic medical centers in 2009. Clinical input varied.
Several reviewers commented on the lack of data (e.g., those who cannot do pelvic exercises) as well as the inability to separate in the available literature the contribution of biofeedback to overall outcomes in many studies.

**Practice Guidelines and Position Statements**

**American Urological Association et al**
In their guidelines on treatment of stress urinary incontinence in women, the American Urological Association and Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction (2017) recommended offering several treatment options including pelvic floor muscle training with biofeedback: “Pelvic floor muscle training and incontinence pessaries are appropriate for patients interested in pursuing therapy that is less invasive than surgical intervention. Pelvic floor physical therapy can be augmented with biofeedback in the appropriate patient. The patient must be willing and able to commit to regularly and consistently performing pelvic floor training for this to be successful.”

The American Urological Association/Society of Urodynamics, Female Pelvic Medicine & Urogenital Reconstruction Guideline (2019) on treating incontinence after prostate treatment states that the randomized controlled trials that were assessed differed on the regimen of pelvic floor muscle training, with some studies including biofeedback or electrical stimulation. Guideline Statement 16 recommends pelvic floor muscle exercises or pelvic floor muscle training but biofeedback is not mentioned as part of the treatment.

**American College of Physicians**
The American College of Physicians (2014) published clinical guidelines on the nonsurgical management of urinary incontinence in women. The guidelines were based on literature published through December 2013. The College concluded that low-quality evidence showed pelvic floor muscle training (PFMT) with biofeedback using a vaginal electromyography probe increased continent compared with no active treatment and that high-quality evidence showed this combination of treatments improved urinary incontinence symptoms compared with no active treatment. The guidelines did not compare PFMT alone and PFMT plus biofeedback.

**National Institute for Health and Care Excellence**
The National Institute for Health and Care Excellence (2019) updated its guidance on the management of urinary incontinence in women. Recommendations on biofeedback included: “do not use perineometry or pelvic floor electromyography as biofeedback as a routine part of pelvic floor muscle training” and “electrical stimulation and/or biofeedback should be considered in women who cannot actively contract pelvic floor muscles in order to aid motivation and adherence to therapy”.

**Canadian Urological Association**

- Preoperative biofeedback-assisted behavioural training can shorten the time to regain continence postoperatively and reduce the prevalence of severe incontinence 6 months after the procedure (level of evidence 2, grade B). Postoperative ... biofeedback does not appear to improve continence outcomes compared with PFMT (level of evidence 2, grade B).

“The benefit of biofeedback is unknown (grade B).”

**National Institutes of Health**
The National Institutes of Health (2007) convened a consensus development conference on prevention of fecal and urinary incontinence; it subsequently released a statement that addressing PFMT and biofeedback...
"Pelvic floor muscle training and biofeedback are effective in preventing and reversing some pregnancy-related fecal and urinary incontinence for the first year after delivery. There is insufficient research on the sustained long-term benefits of pelvic floor muscle training or biofeedback on preventing fecal or urinary incontinence."

**U.S. Preventive Services Task Force Recommendations**
Not applicable.

**Medicare National Coverage**
The Centers for Medicare & Medicaid (2001) issued a national coverage determination. It states:
"This policy applies to biofeedback therapy rendered by a practitioner in an office or other facility setting.

Biofeedback is covered for the treatment of stress and/or urge incontinence in cognitively intact patients who have failed a documented trial of pelvic muscle exercise (PME) training. Biofeedback is not a treatment, per se, but a tool to help patients learn how to perform PME. Biofeedback-assisted PME incorporates the use of an electronic or mechanical device to relay visual and/or auditory evidence of pelvic floor muscle tone, in order to improve awareness of pelvic floor musculature and to assist patients in the performance of PME.

A failed trial of PME training is defined as no clinically significant improvement in urinary incontinence after completing 4 weeks of an ordered plan of pelvic muscle exercises to increase periurethral muscle strength.

Contractors may decide whether or not to cover biofeedback as an initial treatment modality. Home use of biofeedback therapy is not covered."

**Ongoing and Unpublished Clinical Trials**
A search of ClinicalTrials.gov in June 2019 did not identify any ongoing or unpublished trials that would likely influence this review.

**References**


**Documentation for Clinical Review**

- No records required
Coding

This Policy relates only to the services or supplies described herein. Benefits may vary according to product design; therefore, contract language should be reviewed before applying the terms of the Policy. Inclusion or exclusion of codes does not constitute or imply member coverage or provider reimbursement.

IE

The following services may be considered investigational.

<table>
<thead>
<tr>
<th>Type</th>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPT</td>
<td>90875</td>
<td>Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes</td>
</tr>
<tr>
<td>CPT</td>
<td>90876</td>
<td>Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes</td>
</tr>
<tr>
<td>CPT</td>
<td>90901</td>
<td>Biofeedback training by any modality</td>
</tr>
<tr>
<td>CPT</td>
<td>90911</td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry <em>(Deleted code effective 1/1/2020)</em></td>
</tr>
<tr>
<td>CPT</td>
<td>90912</td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; initial 15 minutes of one-on-one physician or other qualified health care professional contact with the patient <em>(Code effective 1/1/2020)</em></td>
</tr>
<tr>
<td>CPT</td>
<td>90913</td>
<td>Biofeedback training, perineal muscles, anorectal or urethral sphincter, including EMG and/or manometry, when performed; each additional 15 minutes of one-on-one physician or other qualified health care professional contact with the patient <em>(List separately in addition to code for primary procedure) (Code effective 1/1/2020)</em></td>
</tr>
<tr>
<td>HCPCS</td>
<td>E0746</td>
<td>Electromyography (EMG), biofeedback device</td>
</tr>
</tbody>
</table>

Policy History

This section provides a chronological history of the activities, updates and changes that have occurred with this Medical Policy.

<table>
<thead>
<tr>
<th>Effective Date</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/11/2008</td>
<td>New Policy Adoption of BCBSA MPP 7.01.106. Content enhanced by merging BSC policies Urinary Incontinence Treatment and Endoscopic Injections for Urinary Incontinence, Codes updated. Policy title change. Prior policy title Urinary Incontinence Treatment.</td>
</tr>
<tr>
<td>03/01/2009</td>
<td>Coding Update</td>
</tr>
<tr>
<td>04/02/2010</td>
<td>Policy Revision with position change</td>
</tr>
<tr>
<td>04/14/2010</td>
<td>Coding Update</td>
</tr>
<tr>
<td>10/29/2010</td>
<td>Coding Update</td>
</tr>
<tr>
<td>01/21/2011</td>
<td>Coding Update</td>
</tr>
<tr>
<td>01/12/2012</td>
<td>Coding Update</td>
</tr>
<tr>
<td>07/03/2013</td>
<td>Policy revision with position change</td>
</tr>
<tr>
<td>02/27/2015</td>
<td>Policy title change from Urinary Incontinence Outpatient Treatment BCBSA Medical Policy adoption Policy revision with position change</td>
</tr>
</tbody>
</table>
Definitions of Decision Determinations

Medically Necessary: Services that are Medically Necessary include only those which have been established as safe and effective, are furnished under generally accepted professional standards to treat illness, injury or medical condition, and which, as determined by Blue Shield, are: (a) consistent with Blue Shield medical policy; (b) consistent with the symptoms or diagnosis; (c) not furnished primarily for the convenience of the patient, the attending physician or other provider; (d) furnished at the most appropriate level which can be provided safely and effectively to the patient; and (e) not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Member’s illness, injury, or disease.

Investigational/Experimental: A treatment, procedure, or drug is investigational when it has not been recognized as safe and effective for use in treating the particular condition in accordance with generally accepted professional medical standards. This includes services where approval by the federal or state governmental is required prior to use, but has not yet been granted.

Split Evaluation: Blue Shield of California/Blue Shield of California Life & Health Insurance Company (Blue Shield) policy review can result in a split evaluation, where a treatment, procedure, or drug will be considered to be investigational for certain indications or conditions, but will be deemed safe and effective for other indications or conditions, and therefore potentially medically necessary in those instances.

Prior Authorization Requirements (as applicable to your plan)

Within five days before the actual date of service, the provider must confirm with Blue Shield that the member's health plan coverage is still in effect. Blue Shield reserves the right to revoke an authorization prior to services being rendered based on cancellation of the member's eligibility. Final determination of benefits will be made after review of the claim for limitations or exclusions.

Questions regarding the applicability of this policy should be directed to the Prior Authorization Department at (800) 541-6652, or the Transplant Case Management Department at (800) 637-2066 ext. 3507708 or visit the provider portal at www.blueshieldca.com/provider.

Disclaimer: This medical policy is a guide in evaluating the medical necessity of a particular service or treatment. Blue Shield of California may consider published peer-reviewed scientific literature, national guidelines, and local standards of practice in developing its medical policy. Federal and state law, as well as contract language, including definitions and specific contract provisions/exclusions, take precedence over medical policy and must be considered first in determining covered services. Member contracts may differ in their benefits. Blue Shield reserves the right to review and update policies as appropriate.